MEDICARE PART B

SECTION B

2010 MEDICARE PART B
MEDICARE SERVICES, BENEFITS, PAYMENT

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY
Medical Expenses Doctor's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, DME, and other services	Unlimited if medically necessary	80% of approved amt. after deductible, 50% of approved amt. for most outpatient mental health services.	**$155** deductible plus 20% of approved amt, and Limiting Charges above that amount
SERVICES	**BENEFIT**	**MEDICARE PAYS**	**YOU PAY**
Clinical Laboratory Services Blood tests, urinalysis, and more.	Unlimited if medically necessary	Generally 100 % of approved amount	Nothing
SERVICES	**BENEFIT**	**MEDICARE PAYS**	**YOU PAY**
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, and other services.	Unlimited as long as you meet Medicare conditions.	100% of approved. Amt. 80% for DME approved amount.	Nothing for services, 20% for DME.
SERVICES	**BENEFIT**	**MEDICARE PAYS**	**YOU PAY**
Outpatient Hospital Treatment Services for the diagnosis or treatment of illness or injury.	Unlimited if medically necessary	Medicare payment to hospital based on hospital cost.	20% of billed amount per procedure code after the deductible. (There may be multiple codes charges during one outpatient visit)
SERVICES	**BENEFIT**	**MEDICARE PAYS**	**YOU PAY**
Blood	Unlimited if medically necessary	80% of approved amt. after the deductible, starting with the 4th pint.	First three (3) pints plus 20% of approved amt. after deductible. (If blood is not replaced by Part A or Part B)

2009 MEDICARE PART B FIGURES

2010 PREMIUM

Yearly Income Filed Individual Tax Return	Yearly Income Filed Joint Tax Return	Monthly Premium
$85,000 or less	$170,000 or less	$96.40
$85,001-$107,000	$170,001-$214,000	$154.70
$107,001-$160,000	$214,001-$320,000	$221.00
$160,001-$214,000	$320,001-$426,000	$287.30
$214,00 or more	$426,000 or more	$353.60

2010 DEDUCTIBLE

$155 per year

LIMITING CHARGE

115% Of Medicare's Approved Amount
This applies when using nonparticipating physicians and some supplies.

MEDICARE PART B

Medicare Part B helps pay for medical services such as doctors' services, outpatient hospital care, and preventive care. Part B is sometimes referred to as medical insurance. Coverage for eligible beneficiaries is **optional**. To decline Part B, contact a Social Security Office for the required forms.

There is a premium for each beneficiary who is receiving Medicare Part B. The Part B premium is normally deducted from your monthly Social Security check, or if you do not receive a monthly check, you will be billed every three months.

Your monthly premium will be based on your annual income. According to CMS, most Medicare beneficiaries will pay the standard premium of $96.40. If your annual income is more than $85,000 and you filed an individual tax return, you will pay a higher premium ($170,000 for a joint tax return). Social Security (SSA) will use the income you reported two years ago to determine your premium. If your income has decreased since 2007, you can request that SSA use a more recent tax year, but you must meet certain criteria. Contact SSA for information on the criteria that must be met to use a more recent year.
[Counselors Note: See chart on page C-2 for details on the premium amounts]

The Part B Deductible & Coinsurance

You are responsible for the Part B deductible, (2010 $155) in each calendar year. Services not covered by Medicare and charges in excess of the Medicare approved charges do not apply toward the deductible. The deductible must be met **only once per calendar year**.

Medicare Part B pays 80% of approved charges for coverage unless otherwise specified. You are responsible for your share **(coinsurance)** of the Medicare approved amount, **which is usually 20% of the approved charges.**

PART B PAYMENT SYSTEM

How Medicare Pays Providers

Part B approved amounts are based on the Medicare **fee schedule amounts.** The fee schedule applies to physicians and certain suppliers nationwide, and lists payments for each Part B service. Geographic variations in the cost of practice is taken into consideration in setting the fee schedule. The fee schedule amount is often **less** than the actual charges billed by physicians and suppliers.

When a Part B claim is submitted, the Medicare carrier **compares** the actual charge shown on the claim with the fee schedule amount for that service. **The Medicare approved amount is the lower of the actual charge, or the fee schedule amount.** Medicare Part B will then usually pay 80% of this approved amount.

Participating in Medicare

Participating in Medicare means that the provider is set up to file a claim with Medicare for services provided. This can also be referred to as being Medicare Approved or Medicare Certified. Not all providers or suppliers are participating. They elect whether or not to participate in Medicare each calendar year.

Finding a Participating Provider/Supplier

A list of local participating providers/suppliers is available by contacting Medicare. To get a copy of this list call **1-800-Medicare (1-800-633-4227).**

This information is also available on the Medicare website:
www.medicare.gov.

Accepting Assignment

Participating providers/suppliers can choose whether or not to accept Medicare Assignment. By accepting Medicare Assignment they are agreeing to accept the Medicare Approved Amount as total payment for the service provided. This is sometimes shown on the physician's bill as an **adjustment**, or a **Medicare allowance amount**.

- Those participating physicians and suppliers agree to take assignment in **all** Medicare cases for the full year.

- After the deductible has been met, Part B pays 80% of the remaining Medicare approved charge, and the beneficiary pays the remaining 20%.

Medicare pays the participating provider or supplier directly.

You are responsible for paying the:

- **Part B Deductible**
- **20% Coinsurance**

Not Accepting Assignment

Not accepting assignment means that a provider or supplier does **not agree to accept** Medicare's approved charge as total payment for services. You must pay these doctors or suppliers directly. **However, the provider must still file the claim with Medicare.** Medicare pays 80% of the approved amount **directly to you.** You are responsible for the remaining charges (the 20% coinsurance and the excess amount over the Medicare approved amount - Limiting Charge).

You may ask a nonparticipating doctor if they would accept assignment on a claim-by-claim basis. If they agree to accept assignment, then you will only be responsible for the 20% coinsurance.

You are responsible for paying the:

- **Part B Deductible**
- **20% coinsurance**
- **any excess amount over the Medicare approved charge**

LIMITING CHARGE

The Limiting Charge is 115% of what Medicare approves. This may also appear as 15% over the Medicare approved amount, or may be called the excess charge.

Physicians and certain suppliers not accepting assignments **may be fined by Medicare** for charging amounts over the Limiting Charge for such services as:

- Portable x-ray suppliers
- Independent labs
- Independent physiological labs
- Independent physical and occupational therapists
- Physician's services which they actually perform themselves

Not every service in a physician's office has a Limiting Charge. Limited Charges apply to a physician's personal services. If you have paid more than the Limiting Charge, ask the physician for a reduction in the charge, or a refund. Credits to an existing account may be given only for services already performed. If you have a **Limiting Charge Problem,** contact **National Government Services (formally AdminaStar Federal)** for assistance**.**

When a physician/supplier **does not accept assignment**, you are responsible for any charges above the Medicare approved amount up to the Limiting Charge, the 20% coinsurance, and the Part B deductible (if this applies).

Special Rule for Non-Participating Doctors and Elective Surgery

If elective surgery is to cost **over $500,** the nonparticipating doctor **must** give the patient a written estimate of Medicare approved charges including the excess costs the physician is charging for the service. If no written estimate is given, the nonparticipating doctor must refund any payments that you have made that were over the approved amount. You are not responsible for anything over the Medicare approved amount. If you are unsure of charges, or whether you have been charged the correct amount, first contact your service provider. If still not satisfied, contact **National**

PART B BENEFITS

Medicare Coverage for Physician Services

Medicare Part B helps pay for covered services received from a **physician** in their office, hospital, skilled nursing facility, patient's home, or any other location in the U.S. These include Doctors of Medicine (MD) or Doctors of Osteopathy (DO).

Doctor's Services Covered

- Medical and surgical services, including anesthesia
- Diagnostic tests and procedures
- Radiology and pathology services (inpatient or outpatient)
- Drugs and biologicals (injectables) that cannot be self administered, except for certain oral cancer drugs
- Transfusions of blood and blood components **after** the third pint
- Services of the doctor's nurse
- Medical supplies and x-rays
- Physical/occupational therapy, and speech pathology services

Limited Coverage for Doctors' Services Include:

Chiropractor: Part B only pays for manual manipulation of the spine to correct a subluxation. National Government Services determines how many visits are medically necessary to treat subluxation. Medicare **will not** pay for x-rays furnished by a chiropractor, or any other diagnostic or therapeutic services the chiropractor provides.

Podiatrist: Part B will **help pay** for covered services provided by a licensed podiatrist to treat injuries and diseases of the foot, such as heel spurs, hammer toe deformities, ingrown toenails, and bunion deformities. **Medicare will not pay for routine foot care**, such as trimming nails, cutting or removal of corns, calluses and most warts. **Note:** There may be exceptions if you are under the active care of a medical doctor for certain medical conditions, such as diabetes or peripheral vascular disease, which require routine care to be performed by a podiatrist, physician or doctor of osteopathy.

Optometrist: Medicare will **not** pay for routine eye exams or eyeglasses. Part B will pay for a licensed optometrist's services that are involved in the treatment and diagnosis of eye disease, cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery. Medicare will also pay for one pair of conventional eyeglasses, or conventional contact lenses if necessary after cataract surgery with insertion of an intraocular lens.

Doctors' Services Not Covered

- Experimental medical procedures and services that Medicare does not consider medically reasonable or necessary.
- Routine physical examinations and tests related to such examinations, with the exceptions of **mammograms and pap tests.**
- Routine foot care.
- Exams for prescribing or fitting of **hearing aids** or **eyeglasses**, with the exception of **one pair** of eyeglasses after cataract surgery.
- Most immunizations, **except** Hepatitis B vaccine for high risk persons, a Pneumococcal Pneumonia vaccine, the Influenza (flu) vaccine **one time** during the flu season, and immunizations required because of an injury or immediate risk of infection.
- Routine dental care or dentures **with the exception** of surgery of the jaw or related structures.
- Acupuncture.
- Cosmetic surgery, unless needed to improve the function of a malformation of the body or from damage from an accident.
- Services rendered by Christian Science practitioners.
- Most prescription drugs.
- Services rendered outside the US-limited coverage in Mexico and Canada.

Second Opinion Before Surgery

A doctor may determine that you need surgery for a non-emergency health problem. Medicare recommends, (and will help pay for) a second doctor's opinion about surgery. Medicare will also help pay for a third opinion if the first and second opinions contradict each other. Your own doctor, or another doctor they trust are good sources for referrals for additional opinions.

Do not wait for a second opinion for emergency surgery. To avoid duplicate testing when seeking a second opinion **for non-emergency surgery**, ask the first doctor's office to send all medical records to the doctor who will be giving the second opinion. ***See Medicare and You handout 'Getting a Second Opinion Before Surgery".***

Services of Special Practitioners

Medicare may help pay for services received from specially qualified practitioners approved by Medicare, and who accept assignment for most of their services. Some of these practitioners are approved by Medicare to practice only in certain facilities or in certain locations, and may include the following:

- Certified registered nurse anesthetist
- Certified nurse midwife
- Clinical psychologist
- Clinical social worker
- Physician assistant
- Nurse practitioner and clinical nurse specialist supervised by a doctor

Coverage of Outpatient Hospital Services

Outpatient services in a participating hospital for diagnosis and treatment of an illness or injury. With each procedure, you are responsible for 20% of the hospital charge up to a maximum limit set by law. This maximum amount equals the Part A hospital deductible. If you have outpatient surgery, the actual surgery could be considered **one procedure** and the **anesthesia another procedure**. Deductibles do apply. Services covered include:

- Emergency room or outpatient clinic, including same day surgery.
- X-rays and other radiology services billed by the hospital.
- Medical supplies such as splints and casts.
- Laboratory tests billed by the hospital.
- Drugs and biologicals which cannot be self administered.
- Blood transfusions furnished to an outpatient after the third pint.
- Mental health care in a partial hospitalization psychiatric program as long as a doctor certifies that inpatient treatment would be required without it.

Outpatient Surgery at an Ambulatory Surgical Center
An ambulatory surgical center can be hospital-affiliated, or independent, but must provide **only** outpatient surgery services. Medicare Part B pays 80% of the approved amount for certain **approved** procedures, physicians, and anesthesia provided in connection with the procedure. The center must be participating in Medicare.

Home Health Care Services
Medicare Part A will usually pay for HHC benefits up to 100 visits **after a three (3) day hospital stay**. Part B pays for HHC benefits when you do not have Medicare Part A. Part B also pays for HHC visits after Part A has paid for 100 visits, and if you have had no hospital stay. The deductible **does not apply** in these cases.

Outpatient Rehabilitation Therapy
Part B helps pay for **medically necessary** outpatient physical therapy, occupational therapy, and speech pathology services. A doctor must prescribe the service and periodically review the plan. Either a doctor or a therapist may set up the plan of treatment.

Two options for service are:

- If you are an outpatient at a Medicare participating hospital, there is no annual limit, and no excess charge for covered services. Medicare pays 80% of the approved charge.

- For services provided at a SNF, home health agency, clinic, rehabilitation agency, public health agency, or comprehensive outpatient rehabilitation facility, there is no annual limit, and no excess charge for covered services. Medicare pays 80% of the approved charge.

Therapy sessions can be delivered by an independently practicing Medicare approved physical or occupational therapist in their office, or in your home if the treatment is prescribed by a doctor.

Comprehensive Outpatient Rehabilitation Facility
Comprehensive Outpatient Rehabilitation Facilities (CORFs) provide skilled rehabilitation services. You **must** be referred by a doctor before Medicare may help pay. A Medicare participating CORF provides physician's services, physical, speech, occupational, and respiratory therapies, and other related services. **The annual Part B deductible and 20% coinsurance apply.**

Federally Qualified Health Center Services
Federally Qualified Health Centers (FQHCs) are Medicare participating clinics, and are located in both rural and urban areas. FQHC benefit services are delivered by physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses, clinical psychologists, or clinical social workers. The FQHCs can explain which services are provided and which are covered. **No Part B deductible is charged** when services are received at a FQHC.

You are **responsible** for the 20% coinsurance for Medicare approved charges unless they are waived. If you are under the FQHC benefit plan, the clinic provides additional services, **you must pay** the Part B deductible and the 20% coinsurance for Medicare approved charges. (Additional services might be x-rays, crutches, etc.)

Rural Health Clinic Services
Medicare will help pay for services at Rural Health Clinics of physicians, nurse practioners, physicians assistants, nurse midwives, visiting nurses, clinical psychologists, or clinical social workers. **At rural health clinics only the 20% coinsurance and the Part B deductible may be charged (no excess charges).**

Outpatient Mental Health Treatment
Services provided by psychiatrists, clinical psychologists, clinical social workers, and other special practitioners can be provided in hospitals, Comprehensive Outpatient Rehabilitation Facilities, community mental health centers, and/or Skilled Nursing Facilities. Medicare pays **approximately 50% (not 80%)** of approved charges.

Outpatient Mental Health Treatment (con't)
On assigned cases, you have coinsurance of 50%. When **not assigned,** you pay the coinsurance, plus any excess charges. Exceptions to the 50% payment limit are partial hospitalization services, and brief office visits for monitoring or changing prescriptions.

Ambulance Coverage
Transportation by ambulance must be **medically necessary**. Ambulance, equipment, and personnel must meet Medicare requirements. When transportation in another vehicle would endanger your health.

Medicare may help pay for transportation from home or the scene of an accident to the local hospital or SNF, or from the hospital or SNF to home. Medicare will **not** pay for ambulance use as routine transportation.

Air ambulance coverage is **limited**, and Medicare may pay when:

- the medical condition is life threatening;
- immediate treatment is required for survival or to avoid severe health damage;
- land transportation is not available;
- in limited cases so time consuming as to endanger life.

When air transportation is **not medically necessary**, Medicare may help pay for the air ambulance, **but at the land ambulance rate**. You pay the difference.

Durable Medical Equipment

Durable Medical Equipment (DME) and supplies are generally paid at 80% of the approved charge. Medicare does **not** cover items that may be necessary but not medical in nature, such as humidifiers, adhesive tape, etc. A physician must order or prescribe the equipment prior to purchasing or renting it, must be medically necessary and be appropriate for use in your home. The supplier must be Medicare certified.

Special Claims Information for Durable Medical Equipment

- Medicare Limiting Charge does not apply to DME claims.
- Nonparticipating suppliers may accept assignment on a case by case basis. With few exceptions, DME suppliers must now file claims with Medicare.
- Medicare usually determines whether an item is to be purchased or rented.

Claims are filed based on your state of permanent residency. When renting or buying medical equipment, you should inform the supplier of your state of residence.

Medicare Covered Durable Medical Equipment and Supplies May Include:

- Oxygen equipment, wheelchairs, power operated vehicles, walking aids, hospital beds, and certain other medical equipment.

- Prosthetic devices that are used to replace or assist body parts, such as: pacemakers, corrective lenses after cataract surgery, ostomy bags and related supplies, breast prostheses and surgical brassieres.

- Artificial limbs and eyes, arm, neck, back and leg braces.

- Orthopedic shoes, (if part of leg braces), and therapeutic shoes for diabetics, (one pair per year of shoes and inserts to avoid amputation).

- Supplies ordered by a physician such as surgical dressings, splints, and casts.

- Some oral cancer and immuno-suppressive drugs.

- Outpatient radiation therapy given under medical supervision.

- Diabetic supplies including: glucose monitors, blood testing strips, and lancets. Before paying for testing strips, Medicare must either purchase a monitor, or a doctor's order must state that you already have a monitor.

- Coverage of infusional insulin and infusion pumps. To qualify, you must test your blood glucose at least 4 times a day, and take at least 3 shots of insulin daily. Type I diabetics must keep a log if testing more than 3 times a day. Type II diabetics must keep a log if testing more than once a day.

Durable Medical Equipment and the Excess Charge
It is important that you find a supplier that accepts Medicare Assignment. Suppliers that do not accept Medicare Assignment are not subjected to a cap on the Limiting Charge. You will pay more out of pocket by using a supplier that does not accept assignment. **This information is not usually posted - you need to ask about assignment.**

If the supplier accepts assignment, you will be responsible for the Part B Deductible, and the 20% coinsurance. **If the supplier does not accept assignment, you will be responsible for the Part B Deductible, and the difference between the Medicare approved amount and the amount charged by the supplier.**

For Example: You need to purchase a cane and have satisfied your Part B deductible. The **Medicare approved amount is $20**. Your supplier bills Medicare for $100.

If the supplier **accepts Medicare assignment**, Medicare will pay $16 (80% of the approves amount) and **you will pay $4** (the 20% coinsurance).
If the supplier **does not accept** assignment, Medicare will pay $16 and **you will be responsible for the remainder of the charges - $84**.

Laboratory Services

Medicare Part B will cover 100% of the approved amount for diagnostic tests, if the following criteria is met:

- The lab must accept Medicare Assignment;
- The lab must bill Medicare, not you; and
- The tests must be coded as diagnostic, not screening.

The lab may be independent, part of a hospital's outpatient department, or in a doctor's office. In laboratories **not participating** in Medicare, Medicare pays 80% of the approved charge. When the lab is independent and nonparticipating, the 15% Limiting Charge applies.

Portable Diagnostic X-Rays
Part B helps pay for these services when physicians order them. Services can be performed in your home, or at other locations. The supplier providing the equipment must be **Medicare approved**. When services are provided by **nonparticipating** portable x-ray suppliers, the 15% Limiting Charge applies.

Independent Physiological Labs
These labs determine the functions and vital processes of the body such as long term EKG and EEG diagnostic services. When services are provided by **nonparticipating independent physiological labs, the 15% Limiting Charge applies**.

Diabetic Supplies

Medicare Part B will cover certain supplies if you have diabetes. These supplies include:

- Blood Sugar Monitors
- Therapeutic Shoes
- Insulin Pumps

Blood Sugar Monitors
Medicare will cover the blood sugar testing monitor as well as the test strips, lancet devices and lancets. You are covered whether or not you are insulin dependent. A prescription from your doctor is required. You must get your supplies from a Medicare participating supplier. You may pay more for your supplies if you use a supplier that does not accept assignment.

If your supplier **accepts assignment, you will pay the 20% coinsurance after the annual Part B deductible has been met**. If your supplier does not accept assignment, Medicare will send you the 80% of the Medicare approved amount and you will be responsible for the remainder of the charges. **Claims to Medicare must be submitted by the supplier.** Beneficiaries can no longer submit claims for diabetic supplies to Medicare.

Therapeutic Shoes
If you have diabetes and meet certain conditions Medicare will cover therapeutic shoes if you need them. The types of shoes covered each year are one pair of depth-inlay shoes and three pair of inserts, or one pair of custom-molded shoes and two additional inserts. In order for Medicare to cover these shoes **you must meet all** of the following conditions:

- You must have diabetes.
- Have **at least one** of the following conditions in one or both feet:
  - Partial or complete foot amputation
  - Past foot ulcers
  - Calluses that could lead to foot ulcers
  - Nerve damage because of diabetes with signs of problems with calluses

    - Poor circulation
    - Deformed foot
- Are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes

Medicare also requires that a podiatrist or other qualified doctor prescribes the shoes. Also that the shoes are fitted and provided by a doctor or other qualified provider like a podiatrist, orthopedist, or prosthetic.

If your provider or supplier **accepts assignment, you will pay the 20% coinsurance after the annual Part B deductible has been met**. If your provider or supplier does not accept assignment, Medicare will send you the 80% of the Medicare approved amount and you will be responsible for the remainder of the charges.

Insulin Pumps

If you need to use an insulin pump worn outside of the body, Medicare may cover the pump as well as the insulin to be used with the pump. You must meet certain conditions and have the doctor prescribe the pump. Work with your doctor to see if you meet the requirements for Medicare to cover the pump.

If your supplier **accepts assignment, you will pay the 20% coinsurance after the annual Part B deductible has been met**. If your supplier does not accept assignment, Medicare will send you the 80% of the Medicare approved amount and you will be responsible for the remainder of the charges.

Medicare Preventive Services

Preventive Service	Frequency	What You Pay
Abdominal Aortic Aneurysms Screening	Once in a lifetime	20% coinsurance; Part B deductible is waived
Bone Mass Measurement	Once every 24 months	20% Coinsurance after deductible
Cardiovascular Screenings	Once every 5 years	Nothing
Colorectal Cancer Screening Fecal Occult Blood Test Flexible Sigmoidoscopy Screening Colonoscopy Barium Enema	Fecal Occult Blood - 12 months Sigmoidoscopy - 24 months Colonoscopy - 48 months; 24 months if high risk Barium Enema - 48 months; 24 if high risk	Fecal Occult Blood Test - Nothing All others 20% coinsurance (if Sigmoidoscopy or Colonoscopy is performed as a hospital outpatient 25%) Part B deductible is waived.
Diabetes Screening	Two per year	Nothing
Flu Shots	One per flu season	Nothing
Glaucoma Tests	Once every 12 months	20% Coinsurance after deductible
Hepatitis B Shots	Three shot series	20% Coinsurance after deductible
HIV Screening Test	Once every 12 months	20% Coinsurance after deductible
Pap Test, Pelvic Exam & Clinical Breast Exam	Once every 24 months; 12 months if high risk	Pap Test - Nothing Pelvic & Breast Exam - 20% Coinsurance; not subject to deductible
Pneumococcal Shot	Talk to your doctor	Nothing
Prostate Cancer Screening (PSA) & Digital Rectal Exam	Once every 12 months	PSA – Nothing Digital Rectal Exam - 20% Coinsurance after deductible
Screening Mammograms	Once every 12 months	20% Coinsurance not subject to deductible
Welcome to Medicare Physical Exam	Once - but must be within the first 12 months of having Part B	20% Coinsurance after deductible

Preventive Services

Bone Mass Measurement

Bone mass measurements help determine if you are at risk for broken bones. The density of your bone is measured. The lower your bone density, the higher your risk is for a fracture. Medicare covers these measurements **once every 24 months** (more often if medically necessary). **You will pay 20% of the Medicare approved amount after the yearly Part B deductible.**

Cardiovascular Screenings

Beginning January 1, 2005, Medicare covers tests for cholesterol, lipids, and triglyceride levels to determine your risk for cardiovascular disease. These tests include the following screenings:

- Total Cholesterol Test
- Cholesterol Test for High Density Lipoproteins (Lipids)
- Triglyceride Test

Medicare covers these tests **once every 5 years**. **You will pay nothing** for these tests - there is no coinsurance and the Part B deductible is waived.

Colorectal Cancer Screening

Medicare covers colorectal screening tests to help find pre-cancerous polyps, so that they can be removed before turning cancerous. These tests are available to all people with Medicare age 50 and older - except for the screening colonoscopy, there is no minimum. These tests include the following:

- **Fecal Occult Blood Test**
  - **Once every 12 months**.
  - **You will pay nothing** - there is no coinsurance and the Part B deductible is waived.
- **Flexible Sigmoidoscopy**
  - **Once every 48 months**.
  - You will pay **20% of Medicare approved amount, the Part B deductible is waived**.

Colorectal Cancer Screening (continued)

- Screening Colonoscopy
    - **Once every 48 months**; once every 24 months if at high risk.
    - If you are not at high risk, payment could not be made for such procedures if performed within ten (10) years of a previous Screening Colonoscopy or 48 months of a Flexible Signoidoscopy screening.
    - **There is no age restriction**.
    - You will pay **20% of the Medicare approved amount, the Part B deductible is waived**..
- Barium Enema
    - **Once every 48 months**; once every 24 months if at high risk.
    - Your doctor can decide to use this test instead of the Flexible Sigmoidoscopy or the Screening Colonoscopy.
    - You will pay **20% of the Medicare approved amount, the Part B deductible is waived**..

Diabetes Screening and Self-Management Training

Beginning January 1, 2005, Medicare covers tests to check for diabetes. These tests are available if you have any of the following risk factors:

- High blood pressure
- History of abnormal cholesterol and triglyceride levels (dyslipidemia)
- Obesity
- History of high blood sugar
- Or two or more of the following characteristics -
    - Age 65 or older
    - Overweight
    - Family history of diabetes
    - History of gestational diabetes (diabetes during pregnancy) , or delivered a baby weighing more than 9 pounds.

Medicare will pay for two diabetes screenings a year. Diabetes screenings that are covered include **fasting plasma glucose tests** and other tests approved by Medicare as appropriate. **You will pay nothing** for these tests - there is no coinsurance and the Part B deductible is waived.

Flu Shots, Hepatitis B Shots and Pneumonia Vaccine

Flu Shot

Influenza or the "flu" is a highly contagious respiratory infection. Symptoms include fever, chills, headache, dry cough, runny or stuffy nose, sore throat, and muscle aches. Unlike other respiratory infections such as a cold, the flu can cause extreme fatigue and last for a week or longer.

According to the Centers for Disease Control every year 5% - 20% of the population get the flu, more than 200,000 people are hospitalized for flu complications, and 36,000 people will die from the flu. Older people, young children and people with certain health conditions are at high risk for serious flu complications.

Complications of the flu can include:

- bacterial pneumonia
- ear infections
- sinus infections
- dehydration
- worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes

Flu Shots are available to anyone with Medicare. Medicare will pay for **one flu shot per flu season**. Medicare determines when the flu seasons are each year. Usually there is one season per year, but there can be more.

If you use a **participating provider, you will pay nothing** for this shot - there is no coinsurance and the Part B deductible is waived. If administered by **a nonparticipating provider, you are responsible for all excess charges. There is no limiting charge.** The provider must file the claim with Medicare - **Medicare will no longer reimburse you** for the cost of the shot.

Hepatitis B Shot

Hepatitis B is caused by a virus that attacks the liver. This virus can cause chronic infection, cirrhosis of the liver, liver cancer, liver failure and death. The Hepatitis B shot is administered in three injections. Hepatitis B Shots are available to Medicare beneficiaries who are medium to high risk for Hepatitis B.

Hepatitis B Shot (cont'd)

Common factors that put you at medium to high risk include:

- Hemophilia,
- ESRD (end-stage renal disease),
- And conditions that lower your resistance to inflection.

You will pay the annual **Part B deductible, and 20% of Medicare approved amount**.

Pneumococcal Vaccine

Pneumococcal Pneumonia is a serious bacterial infection. It kills more people in the United States each year than all other vaccine preventable diseases combined. **You are at risk if . . .**

- **You are 65 and older**,
- You have serious long-term health problems or
- You have increased susceptibility to infection.

Pneumococcal pneumonia is often characterized by sudden onset of illness with symptoms including shaking, chills, fever, shortness of breath or rapid breathing, pain in the chest that is worsened by breathing deeply, and a productive cough. **Pneumococcal Vaccine** is available to all Medicare beneficiaries. **Most people only need this vaccine once in their lifetime.** If you use a participating provider, **you will pay nothing** for this shot - there is no coinsurance and the Part B deductible is waived. If you use a nonparticipating provider, you are responsible for all excess charges. **There is no limiting charge.**

Glaucoma Tests

Glaucoma is an eye disease caused by high pressure in the eye. It can cause you to gradually lose your eyesight without warning and often without symptoms. The best way to protect your eyesight is to have regular eye exams. Your risk for glaucoma increases if you . . .

- Have diabetes
- Have a family history of glaucoma,
- Are African-American age 50 and older, or
- Are Hispanic age 65 and older.

Medicare covers glaucoma tests for beneficiaries who are at high risk for glaucoma. Medicare will help pay for glaucoma tests **once every 12 months.** You will pay the annual **Part B deductible, and 20% of Medicare approved amount**.

Pap Test/Pelvic Exam/Clinical Breast Exam

As part of your Medicare benefits, Medicare covers Pap test and a pelvic exam to check for cervical and vaginal cancers. The pelvic exam also includes a clinical breast exam to check for breast cancer. According to the American Cancer Society (ACS) **Cervical Cancer was once the number one cause of cancer death in women**, but since the use of Pap tests to detect cancer the number of deaths has declined.

This preventive service is **available to all women** who have Medicare. Medicare will cover the Pap test and pelvic exam **once every 24 months.** However, if you are of childbearing age and have had an abnormal Pap test within the past 36 months, or if you are at **high risk** for cervical or vaginal cancer, Medicare will cover a Pap test and pelvic **exam every 12 months**.

You do not pay anything for the Pap test lab work. You will pay a 20% coinsurance of the Medicare approved amount for the Pap collection, pelvic and breast exams. **The Part B deductible is waived.**

Prostate Cancer Screening

Prostate cancer can often be found early by testing the Prostate Specific Antigen (PSA) levels in your blood. Another method of early detection is a digital rectal exam. While all men are at risk for prostate cancer your risk increases . . .

- If you have a father, brother or son who has had prostate cancer - especially if they were young when diagnosed
- If you are African-American
- As you get older - 2 out of every 3 cases of prostate cancer are found in men over 65.

Medicare covers both PSA blood tests and digital rectal exams. This preventive service is available to men on Medicare age 50 and older. Coverage begins the day after your 50th birthday. Medicare will cover these tests once every 12 months

- **PSA** blood test - No coinsurance, and the Part B deductible is waived.
- Digital rectal examination - You will pay the annual **Part B deductible, and 20% of Medicare approved amount**.

Screening Mammogram

Breast cancer is the most common non-skin cancer in women and the second leading cause of cancer deaths in American women. **Every woman is at risk, and this risk increases with age.** With early detection, breast cancer can usually be successfully treated. While all women are at risk for breast cancer, your risks increase if you . . .

- Had breast cancer in the past
- Have a family history of breast cancer
- Had your first baby after 30
- Have never had a baby
- Used hormone replacement therapy for a long time after menopause
- Have 2 or more alcoholic drinks every day
- Are overweight
- Do not exercise

Medicare will help cover mammograms performed in an FDA certified facility, and will accept FDA certification as evidence that the facility is qualified. **All women 40 and older can get a screening every 12 months**. Exams should be scheduled so that they are after the 11th month (i.e. if your last mammogram was February 15, 2009 - you can schedule your next screening February 1, 2010 or later). Medicare will pay for **one baseline mammogram for women between 35 and 39 years old.**

The Part B deductible is waived, but you will need to pay the 20% coinsurance of Medicare approved amount.

Note: Diagnostic mammograms are covered when there are signs or symptoms **present,** at 80% of the Medicare Fee Schedule Amount, and the **Part B deductible is charged.** The Medicare Fee Schedule Amount varies nationwide based on geographic location, and whether or not the physician is a Medicare participating physician. Medicare will cover a diagnostic mammogram when the doctor has specific reasons for ordering the test, regardless of your age.

Welcome to Medicare Physical Exam

Beginning January 1, 2005, anyone whose Medicare Part B began on or after January 1, 2005, is eligible for a one time preventive physical exam. **This exam must be done within the first 12 months you have Medicare Part B.** The exam will include a thorough review of your health, education and counseling about the preventive services you need like certain screenings, shots and referrals for other care if you need it.

During the exam your doctor will record your medical history and check your blood pressure, height, and weight. Your doctor may also give you a vision and electrocardiogram (EKG). Depending on your general health and medical history, further tests may be ordered if necessary.

Your doctor will also give you advice to help you prevent disease, improve your health or stay well. You will also get a written plan (such as a checklist) when you leave letting you know which screenings and other preventive services you should get.

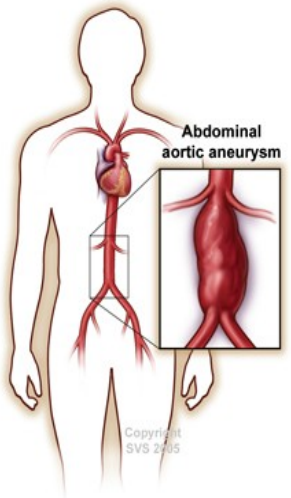
You should bring the following things with you when you go to your "Welcome to Medicare" physical exam:

- Medical records, including immunization records (if you are seeing a new doctor for the first time)
- Family health history - try to learn as much as you can about your family's health history before your appointment. Any information you can give your doctor can help determine if you are at risk for certain diseases.
- A list of prescription drugs that you currently take, how often you take them, and why

You pay 20% of the Medicare approved amount - the Part B deductible is waived (as of January 1, 2009). Since this may be your first Medicare covered service, you may meet your entire Part B deductible at this visit.

Remember this exam is only covered during the first 12 months you have Medicare Part B.

Abdominal Aortic Aneurysms Screening



Starting January 1, 2007 Medicare will cover one ultrasound screening for Abdominal Aortic Aneurysms (AAA) under Medicare Part B. Payment may be made for a one-time ultrasound screening for AAA for people with Medicare who meet the following criteria:

- receives a referral for an ultrasound screening as a result of an initial preventive physical examination
- receives ultrasound screening from a provider or supplier who is authorized to provide the service under Medicare
- has not been previously furnished an ultrasound screening under the Medicare Program and is included in at least one of the following risk categories:
    - has a family history of abdominal aortic aneurysm; or
    - is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime
    - is a beneficiary who has other risk factors.

Medicare will pay for this screening **once in a lifetime**. **The Part B deductible is waived, but you will need to pay the 20% coinsurance of Medicare approved amount**.

Smoking Cessation Counseling

Quitting smoking has significant health benefits, even in older adults who have smoked for years. This preventive service is covered if you have an illness caused or complicated by tobacco use, or if you take medication affected by tobacco use.

Medicare will **cover 8 cessation counseling sessions per year.** These can be received as an inpatient or outpatient. You will pay the annual **Part B deductible, and 20% of the Medicare approved amount**.

Medicare drug coverage can help pay for drug therapy such as nicotine patches.

Kidney Dialysis and Transplants

Medicare Part B helps pay for:

- Maintenance Dialysis
- Kidney Transplant Surgery
- Epoetin Alfa (EPO)
- Home Dialysis Equipment
- Support and Supplies
- Self-Dialysis Training
- Nutrition Therapy Services
- Drugs used in immunosuppressive therapy to prevent rejection of transplanted organs

For more detailed information see the ***Medicare Coverage of Kidney Dialysis and Kidney Transplant Services Handbook.***

Heart and Liver Transplants

Medicare Part B may help pay for:

Under certain conditions, heart and liver transplants in a Medicare approved facility.

Drugs used in immunosuppressive therapy to prevent rejection of transplanted organs. Coverage begins with the date of discharge from a hospital stay as an inpatient receiving an approved organ transplant.